STYLE OF CASE : **ARTURO ELIZONDO**

vs.

ADHAN ABBIKADIR AND
MBA TRANSPORT OF COLUMBUS, LLC

CASE NO. : **1:19-CV-00459**

PERTAIN TO : **Arturo Elizondo**

FROM :

Tideport Distributing Inc. - Personnel

4225 Research Forest Drive, Suite 204
SpringTX77381

DELIVER TO : **George P. Pappas**
Sheehy, Ware, & Pappas, P.C.
909 Fannin Street, Suite 2500
Houston, TX 77010-1003

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
BEAUMONT DIVISION

Order No. **83049.019**

EXHIBIT
3

IN THE UNITED STATES DISTRICT COURT
FOR THE Eastern DISTRICT OF TEXAS
Beaumont DIVISION

ARTURO ELIZONDO	:	
	:	
	:	
vs.	:	CIVIL ACTION NO. **1:19-CV-00459**
	:	
ADHAN ABBIKADIR AND	:	
MBA TRANSPORT OF COLUMBUS, LLC	:	

DIRECT QUESTIONS TO BE PROPOUNDED TO THE WITNESS

Custodian of Records for: **Tideport Distributing Inc.**
Records Pertaining To: **Arturo Elizondo**
Type of Records: **Any and all personnel and/or employment records, including but not limited to, application for employment, insurance records, workers' compensation records, medical records, personnel files, performance reviews, reprimands, records of disciplinary actions, and any other records contained in the employee's file**

1. Please state your name, the name of your employer, and your position and title with said company.

   Answer: TINA RAIDER - HUMAN RESOURCES

2. Please state whether or not the above-named person is or has been an employee of said company.

   Answer: YES CURRENTLY AN EMPLOYEE

3. State whether or not personnel records of the company's employees, including that of the above-named person, are kept and maintained by said company.

   Answer: YES

4. State whether or not the maintenance and preservation of the personnel records, including that of the above-named person, of said company, are kept under your custody and supervision?

   Answer: YES

5. Please state whether or not you are Custodian of Personnel Records of said company.

   Answer: YES

6. Are the personnel records, including the personnel records of the above- named person, made and maintained by the company in the usual and regular course of business?

   Answer: YES

7. Do you have the personnel records of the above-named person?

   Answer: YES

8. Please state whether the entries of the personnel records were made at or near the time of the act, event or condition recorded, or reasonably soon thereafter.

Answer: YES

9. Please state whether it was the regular course of business of your company for an employee or representative with personal knowledge of such act, event or condition to make such memorandum or record, or to transmit information thereof to be included in such personnel records.

Answer: YES

10. Please hand all of the personnel records, pertaining to the above-named person, as outlined in the subpoena duces tecum, to the Officer taking the deposition for photocopying and marking as Exhibits, to be attached to this deposition. Have you done so? If not, why?

Answer: YES

Tina Carder
WITNESS (Custodian of Records)

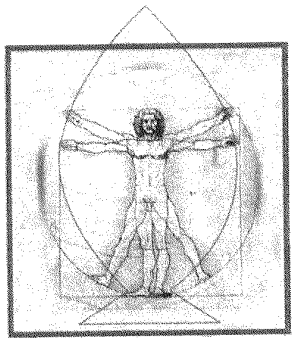
Before me, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument in the capacity therein stated, who being first duly sworn, stated upon his/her oath that the answers to the foregoing questions are true and correct. I further certify that the records attached hereto are exact duplicates of the original records.

SWORN TO AND SUBSCRIBED before me this 14 day of April, 2020.

NOTARY PUBLIC STATE OF TEXAS
ANDREW NATHO
MY COMMISSION EXPIRES
NOVEMBER 5, 2022
NOTARY ID: 11369823

NOTARY PUBLIC

My Commission Expires: _____



GONZALEZ
FAMILY & OCCUPATIONAL MEDICINE
13125 East Freeway
Houston, Texas 77015
713-453-8328 Phone 713-453-6251 Fax
www.gonzalezmd.com

06/25/2018

Applicant's Name Arturo Elizondo JR.

This applicant states he is able to perform the essential functions required by the job for which he is being examined.

Furthermore, there are no findings on the physical examination which would contradict this statement and therefore, we ~~find this~~ applicant able to perform the essential functions of this job (with/without) accommodations.

This release is pending blood, urine, or x-ray results, if required by your company.

Julian Gonzalez

Julian J. Gonzalez, M.D.

Form MCSA-5875 (Revised: 12/09/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

Last Name: Elizondo First Name: Arturo Middle Initial: — DOB: [redacted] Exam Date: 6/25/18

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	✓	○
2. Seizures, epilepsy	○	!	○
3. Eye problems *(except glasses or contacts)*	○	✓	○
4. Ear and/or hearing problems	○	✓	○
5. Heart disease, heart attack, bypass, or other heart problems	○	✓	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	✓	○
7. High blood pressure	○	✓	○
8. High cholesterol	○	✓	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	✓	○
10. Lung disease *(e.g., asthma)*	○	✓	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	✓	○
12. Stomach, liver, or digestive problems	○	✓	○
13. Diabetes or blood sugar problems	○	✓	○
Insulin used	○	✓	○
14. Anxiety, depression, nervousness, other mental health problems	○	✓	○
15. Fainting or passing out	○	✓	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	✓	○
17. Unexplained weight loss	○	✓	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	✓	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	✓	○
20. Neck or back problems	○	✓	○
21. Bone, muscle, joint, or nerve problems	○	✓	○
22. Blood clots or bleeding problems	○	✓	○
23. Cancer	○	✓	○
24. Chronic (long-term) infection or other chronic diseases	○	✓	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	✓	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	✓	○
27. Have you ever spent a night in the hospital?	○	✓	○
28. Have you ever had a broken bone?	○	✓	○
29. Have you ever used or do you now use tobacco?	○	✓	○
30. Do you currently drink alcohol?	○	✓	○
31. Have you used an illegal substance within the past two years?	○	✓	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	✓	○

Other health condition(s) not described above: ○ Yes ✓ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ✓ No ○ Not Sure

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: Arturo Elizondo Jr Date: 06/23/2018

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Pt Denies Chest Pain. Non Smoker

Form MCSA-5875 (Revised: 12/09/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

Last Name: Elizondo First Name: Arturo Middle Initial: ___ DOB: [redacted] Exam Date: 6/25/18

TESTING

Pulse rate: 96 Pulse rhythm regular: (●) Yes ( ) No Height: 5 feet 9 inches Weight: 156 pounds BMI = 23

Blood Pressure	Systolic	Diastolic
Sitting	132	78
Second reading (optional)		

Other testing if indicated

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.015	Neg	Neg	Neg

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/30	20/___	Right Eye: 85 degrees
Left Eye:	20/40	20/___	Left Eye: 85 degrees
Both Eyes:	20/30	20/___	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	(●)	( )
Monocular vision	( )	(●)
Referred to ophthalmologist or optometrist?	( )	( )
Received documentation from ophthalmologist or optometrist?	( )	( )

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ( ) Right Ear ( ) Left Ear (●) Neither

Whisper Test Results

	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	5 feet	5 feet

OR

Audiometric Test Results

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	(●)	( )	8. Abdomen	(●)	( )
2. Skin	(●)	( )	9. Genito-urinary system including hernias	(●)	( )
3. Eyes	(●)	( )	10. Back/Spine	(●)	( )
4. Ears	(●)	( )	11. Extremities/joints	(●)	( )
5. Mouth/throat	(●)	( )	12. Neurological system including reflexes	(●)	( )
6. Cardiovascular	(●)	( )	13. Gait	(●)	( )
7. Lungs/chest	(●)	( )	14. Vascular system	(●)	( )

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

Form MCSA-5875 (Revised: 12/09/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

Last Name: Elizondo First Name: Arturo Middle Initial: ___ DOB: [redacted] Exam Date: 6/25/18

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: _____

⊘ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

(if amended) Medical Examiner's Signature: _____ Date: _____

○ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: Billie Botello

Medical Examiner's Name *(please print or type)*: Billie Botello

Medical Examiner's Address: 13125 East Freeway City: Houston State: Texas Zip Code: 77015

Medical Examiner's Telephone Number: 713-453-8328 Date Certificate Signed: 06/25/2018

Medical Examiner's State License, Certificate, or Registration Number: AP133818 Issuing State: TX

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☒ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: 5970250454 Medical Examiner's Certificate Expiration Date: 06/25/20

Form MCSA-5875 (Revised: 12/09/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

PRIVACY ACT STATEMENT: ***This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.***

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).

ACKNOWLEDGMENT: ***I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.***

Driver's Signature: Arturo Olguin Jr Date: 06/25/2018

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: Elizondo First Name: Arturo Middle Initial: ____ Date of Birth [redacted] Age: 69

Street Address: _____ City: Houston State/Province: Tex Zip Code: 77072

Driver's License Number: [redacted] Issuing State/Province: Tex Phone: 346-312-1425 Gender: ☑ M ○ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ☑ Yes ○ No

Driver ID Verified By**: Key Altro

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ☑ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ Yes ☑ No ○ Not Sure

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ Yes ☑ No ○ Not Sure